

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 3-7-02.
 - b. The request was received on 7-18-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60
 - b. HCFAs
 - c. TWCC 62s
 - d. Example EOBs
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to Request for Medical Dispute Resolution
 - b. HCFAs
 - c. TWCC 62s
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 8-26-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 8-27-02. The response from the insurance carrier was received in the Division on 9-10-02 . Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Position statement taken from Table of Disputed Services:
"We feel we are due an additional payment for the equipment we gave this patient [sic] we have submitted all documentation including copies of the pre-auth request & letter and examples of payments by other carriers. This carrier still denies additional payment."
2. Respondent: Letter dated 9-10-02:

“The provider has not shown it is entitled to any additional reimbursement for the bone growth stimulator. Under Rule 133.307 (g) (D), if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation should discuss, demonstrate, and justify that the payment amount being sought is a fair and reasonable rate of reimbursement. The provider’s documentation fails to demonstrate that the amount requested is a fair and reasonable rate of reimbursement.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 3-7-02.
2. The carrier denied the billed services as reflected on the EOBs as, “M – Payment recommendation based on fair and reasonable which has defined as the Texas 2002 Medicare DME Fee Schedule plus 20%.”
3. The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT or Revenue CODE | BILLED | PAID | EOB | MARS | REFERENCE | RATIONALE: |
|---------------|---------------------|------------|------------|-----|------|-------------------------------------|--|
| 3-7-02 | E0748-NU | \$5,000.00 | \$4,184.82 | M | DOP | MFG GI (VIII) (A); HCPCS descriptor | The “NU” modifier is not recognized in the Commission’s ’96 MFG. For this reason, MRD is unable to determine proper reimbursement for the DME in dispute. Therefore, no additional reimbursement is recommended. |
| Totals | | \$5,000.00 | \$4,184.82 | | | | The Requestor is not entitled to additional reimbursement. |

The above Findings and Decision are hereby issued this 26th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

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